Portsmouth City NHS
Teaching Primary Care Trust

PORTSMOUTH CITY TEACHING PCT

DUAL DIAGNOSIS STRATEGY

Version Number:	**0.1**
Document Date:	**April 2008**
Author:	**Dual Diagnosis Steering Group**

DUAL DIAGNOSIS STRATEGY

1.Executive Summary

Substance Misuse is usual rather than exceptional amongst people with severe mental health problems.

The Dual Diagnosis Good Practice Guide has stated that individuals with dual problems require good quality integrated services and this should be delivered within mental health services.

A local audit has identified significant prevalence across the statutory mental health and substance misuse services.

Practitioners and service users experience difficulties in accessing services, particularly around accommodation.

Certain groups of individuals are emphasised in the Dual Diagnosis Good Practice Guide as requiring special attention and practitioners working in these areas were interviewed to identify local themes. These include people who are homeless, offenders, women, young people and Black and Ethnic Minority communities.

The aim of this strategy is to provide a framework which enables people with a dual diagnosis to receive a “high quality, patient-focussed and integrated care” (Dual Diagnosis Good Practice Guide) which is delivered within mainstream services.

2. Introduction

Historically, substance misuse and mental health services have evolved separately. Few services currently exist which explicitly deal with clients with both substance misuse and mental health problems. These clients have tended either to be treated within one service alone, which has meant that some aspects of their problems have not been dealt with as well as they might, or have been shuttled between services, with a corresponding loss of continuity of care. Some potential clients or patients have almost certainly been excluded from all the available services. The provision of integrated care for people with a combination of mental health problems and substance misuse requires needs to be organised around the user rather than around social, professional or service constructions of “abnormal” behaviour

A fundamental problem has been the lack of a clear definition of ‘dual diagnosis’ which would then enable the development of a Care Pathway, to direct people to the correct service

This strategy is focussed on service users who have severe and enduring mental health problems alongside substance misuse and therefore meet the

eligibility criteria for secondary care mental health services. It does not address the issue of low level mental health problems and substance misuse

3. Definition of Dual Diagnosis

Mental Health Policy Implementation; Dual Diagnosis Good Practice Guide (DOH 2002)

The term 'dual diagnosis' covers a broad spectrum of mental health and substance misuse problems that an individual might experience concurrently. The nature of the relationship between these two conditions is complex. Possible mechanisms include:

- A primary psychiatric illness precipitating or leading to substance misuse
- Substance misuse worsening or altering the course of a psychiatric illness
- Intoxication and/or substance dependence leading to psychological symptoms
- Substance misuse and/or withdrawal leading to psychiatric symptoms or illnesses

Services need to be clear at the outset which individuals they intend to provide interventions for. Defining the population of people who experience these dual problems, and identifying those sub-groups for whom your service has responsibility are necessary steps in this process. Though little consensus is evident in the literature regarding such definitions Figure 1 presents one approach. The horizontal axis represents severity of mental illness and the vertical axis the severity of substance misuse. Case examples in each of the quadrants are also provided to aid clarity. This guide focuses on clients falling within the top right hand quadrant although a proportion of clients falling in the bottom right hand quadrant may also require some of the interventions and approaches described in this guide.

In practice within the United Kingdom the term dual diagnosis is more specifically restricted to include severe mental illness, psychosis, schizophrenia, bipolar affective disorder and substance misuse. A further group that would benefit from a co-ordinated approach are those identified with personality disorders.

Whatever the circumstances a collaborative approach from all involved is required to ensure adequate care pathways.

The Dual Diagnosis Good Practice Guidelines 2002 makes it clear that the responsibility for treating this vulnerable and troubled group lies with mental health services. Drug/alcohol specialists should help and fully support with

advising, training and essential close collaborative working. It states that all mental health services must be subject to the Care Programme Approach (CPA,1999) a process that guarantees a minimum service based upon individual need. The Dual Diagnosis Guidance, (2002), further states that the focus of dual diagnosis should be on 'those with severe mental illness and drug/alcohol

Common mental health problems complicated with substance misuse are often treated within specialist services, however, the National Service Framework (NSF) 1999 states it should be within primary care. Evidence suggests that this latter group are high risk with regards to self-harm, suicide and harm to others (Safer Services 1999)

4.Prevalence – National Studies

According to the Department of Health :Drug Misuse and dependence – UK Guidelines on clinical management (2007)…

'Many large epidemiological surveys demonstrate the high prevalence of co-morbidity in those attending mental health services and drug and alcohol treatment services (Regier et al.,1990, Kessler et al., 1994, Menezeset al.,1996), Weaver et al., (2003) found that 44% of community mental health patients had reported problematic drug use or harmful alcohol use in the previous year. In drug and alcohol treatment services, 75% and 85% of patients respectively had a past year psychiatric disorder – most had affective disorders (depression) and anxiety disorders' (**Table 1**).

'Almost 30% of the drug treatment population and over 50% of those in treatment for alcohol problems experienced 'multiple' morbidity (co-occurrence of a number of psychiatric disorders or substance misuse problems). In the National Treatment Outcomes Research Study, 29% of new admissions reported having suicidal thoughts in the previous three months and 10% reported having a psychiatric hospital admission (Gossop et al.,1998). Personality disorder was reported in 37% of those attending drug services and in 53% of alcohol service users. The usefulness of personality disorder in diagnosis is in marking severity of personality traits, and in pointing to the appropriate treatment, complex needs and possible requirements for pharmacotherapy and structured psychotherapies.'

Table 1 – Presence of co-morbidity in drug and alcohol services (adapted from Weaver et al., 2004)

	Drug Services (Total 16)	Alcohol Services (Total 62)
Schizophrenia	3%	3%
Bipolar affective disorder	1%	5%
Non-specific psychosis	5%	11%
Personality Disorder	37%	53%
Affective and Anxiety disorders	68%	81%
Severe Depression	27%	34%
Mild Depression	40%	47%
Severe Anxiety	19%	32%

5.Needs Assessment / Specific Groups

Certain groups of individuals are emphasised in the Dual Diagnosis Good Practice Guide as requiring special attention and practitioners working in these areas were interviewed to identify local themes

Young People

Substance Misuse is identified as a major contributory factor in the development of mental health problems in the young. Early onset of substance misuse is linked with higher rates of major depressive disorders and it is estimated that a third of young people committing suicide are intoxicated with alcohol at the time of death (Dual Diagnosis Good Practice Guide).

Locally it was reported that young people are frequently referred to agencies for behavioural reasons that make their management within the home environment difficult or because their behaviour has resulted in homelessness. These behaviours are given a variety of definitions although it is clear that substance misuse problems play a major part. The Behaviour Resource Centre (BRS) report that 50% of young people over 10 years of age, referred to them, have a substance misuse problem. This is more commonly alcohol but also amphetamine and other stimulant drugs.

In addition, there are problems in referring young people on to adult services – the transition period. Adult services are often not child-friendly and unlikely to engage young people who may already be leading chaotic lives. There is also a lack of compatibility between young person's and adult services which can mean young people being excluded on diagnosis alone. For example, there are no adult services currently working with people with a mild to moderate learning disability although the BRS reports 60% of those referred to them have this diagnosis.

Homeless People

Studies have highlighted high levels of concurrent substance misuse and mental health problems amongst the homeless and rough sleepers. Homelessness almost trebles a young person's chance of developing a mental health problem (Dual Diagnosis Good Practice Guide 2002).

The main problem identified by those working with homeless people locally was the Eligibility Criteria of statutory mental health and substance misuse services and frustration at the perceived excessive "gate-keeping" into services. Other problems identified were:

- Information on people who access a range of services is not always shared leading to duplication in assessments and information on risk not being available.

- Assessment of mental health and substance misuse are done separately leading to the individual being pulled between services and the existence of one problem being used to deny access – e.g. "we cannot assess until they have stopped drinking / drug using".

- Where people are accommodated without access to specialist services the housing provider is left managing the risk to the individual, other residents and staff.

- Practitioner anxiety and lack of adequate training in this area.

- Difficulties working with Section 8 of the Drug Misuse Act and fear of prosecution. It was reported that local guidance is unclear and leads to people with a continuing illicit drug problem being less likely to be offered accommodation.

- Street level workers may not be trained to arrive at a reliable assessment of both mental health and substance misuse and access to a specialist assessment may not be available within a reasonable timescale.

- Alcohol is the most common drug of use reported by practitioners working with homeless people but this is not reflected in government policy.

Offenders

Nationally, mental health and substance misuse play a major role in youth offending. The UK's Drug Strategy necessitates partnership with the Criminal Justice System and in-reach into detained offenders. Prisoners also have a high level of mental disorder and substance misuse.

Practitioners working with offenders in the city reported similar problems to homelessness workers with access to quick and effective assessment being a major problem. Other issues raised were:

- Problems with inadequate referral information especially when there is no identified keyworker at referral e.g. on release from prison.

- Lack of accommodation including 'wet' housing and providers tolerant of continued substance misuse.

- No commonly accepted risk assessment tool by providers of accommodation.

- Forensic history adds to the complexity of need, more agencies are involved and there is a greater need for improved access and engagement if interventions are to be effective.

- Practitioners report a high level of Personality Disorder which often excludes people from treatment and affects engagement.
- Violent offences and offences against property (e.g. arson) increase the difficulties in accessing accommodation.

Women

The Dual Diagnosis Good Practice Guide outlines the significant differences which have been found between men and women in their patterns of substance misuse and psychiatric co-morbidity:

- Women who misuse substances are significantly more likely than other women or men to have experienced sexual, physical and / or emotional abuse as children.

- Substance misuse lifestyles can impact on women's sexual health and establish a pattern of re-victimisation.

- Women are more likely to present at mental health or primary care services for psychological difficulties rather than for any associated substance misuse problem.

- Women therefore tend to access alcohol and drug services later than men, and this may explain their more severe presentation.

- Women may have children, or want children, and this can deter them from contact with statutory services for fear of their children being removed.

The Women's Mental Health Strategy (DOH 2002) requires the development of services which are attractive to women and sensitive to their need. In dual diagnosis services this requires services to be informed and sensitive to the needs of childhood sexual abuse survivors.

Locally, practitioners report that women often present with high risk behaviours such as self-harming, vulnerability to sexual violence, exploitation by men and chaotic / 'binge' use of alcohol and other drugs.

There are few women-only services available to women with a dual diagnosis and risks of sexual exploitation are increased in mixed gender services, especially in-patient wards where alcohol and drugs are available.

People from Ethnic Minorities

Definitive studies on the influence of culture and ethnicity upon individuals with a dual diagnosis have yet to be conducted but it is known that severe mental illness and substance misuse present difficulties across cultures and ethnic groups. Ethnicity is associated with poor access to services generally and with different meanings and values attributed to drugs and alcohol.

Views expressed by practitioners reflect the national picture that this group of service users continue to view substance misuse and mental health services as being inaccessible to them, they are therefore in 'double jeopardy' if suffering a dual diagnosis with the problems of access already detailed. There are anecdotal views that, due to access difficulties, people approach services later and with more entrenched problems.

6.Outcomes

Substance misuse among individuals with psychiatric disorders has been associated with significantly poorer outcomes including:

- Worsening psychiatric symptoms.
- Increased use of institutional services.
- Poor treatment compliance.
- Homelessness.
- Increased risk of HIV infection.
- Poor social outcomes including impact on carer's and family.
- Contact with the Criminal Justice System.

Substance misuse is also associated with increased rates of violence and suicidal behaviour. A review of inquiries into homicides committed by people with a mental illness identified substance misuse as a factor in over half the cases, and substance misuse is over-represented among those who commit suicide.

Of equal importance are those ailments that result more directly from the administration of substances regardless of a coexistent mental illness. Intravenous drug misuse, for example, can result in venous or arterial thrombosis, blood-borne infections including HIV and Hepatitis B and C, and cardiac disease. Smoking substances, particularly crack and heroin, can result in respiratory diseases including pneumonia and emphysema. Long-term alcohol use is also associated with such debilitating conditions as Korsakoffs Syndrome, delirium and seizures. To overlook or neglect substance misuse in the course of mental health treatment will result in poor treatment outcome.

The above physical complications make it vital that Primary Care services are engaged in the development of services for people with a dual diagnosis. Although the majority of people will be managed by specialist services, Primary Care will be responsible for general health care. Shared-care arrangements will also involve GP's working with dual diagnosis patients.

7.Treatment Approaches

The Dual Diagnosis Good Practice Guide highlights the following stages of treatment to be included in any service model for this group:

Engagement – this should be non-confrontational, empathic and respectful of the client's subjective experience of substance misuse. It may also have to focus on meeting a client's immediate practical need rather than focusing on the cessation of substance misuse.

Motivation for change – the purpose is to strengthen a person's motivation and commitment to change whilst avoiding confrontation and resistance. Techniques include detailing objective assessment of the current situation, pros and cons of continual use, barriers to change etc.

Active treatment – it needs to be acknowledged that it may take some time before the person is ready to engage in active treatment interventions for their substance misuse, it may be more appropriate to focus on harm reduction.

Evidence-based interventions for this group are limited in the UK and most research evidence comes from American studies. Components seen as critical for effective treatment of dual conditions are:

- Integrated treatment.
- Staged interventions.
- Assertive outreach.
- Motivational interventions.
- Individual counselling.
- Social support interventions.
- Long-term perspective.

Relapse prevention – given the chronic relapsing nature of substance misuse it is important that interventions focus on identifying high-risk situations and rehearsing coping strategies. As people may be in different stages in relation to their mental health and substance misuse, it is important that interventions are flexible and that the workforce is skilled in working in this way.

8. Consultation

Over the last five years there have been a significant number of working groups and workshops held locally, regionally and nationally to discuss how best to provide comprehensive services for people with dual diagnosis. In December 2005, a small group of Portsmouth senior managers from mental health and substance misuse services agreed four potential models of service for further local consultation.

9.Model of Care for Portsmouth

In addition to the results of this local consultation is recognition that any new investment is extremely unlikely within the current economic climate of financial constraint and that the model of care needs to be affordable within current resources.

The Department of Health guidance suggests that there is a risk that isolated dual diagnosis specialists could become burned out or disconnected from wider knowledge and developments and that specialist teams focussing exclusively on their own caseloads will not be able to support mental health or drug and alcohol services more widely.

The agreed model of care for Portsmouth is a move away from specialist workers in favour of a more integrated model of care supported by a comprehensive training and development programme across all staff groups and the development of a network of experts against a backdrop of a clear care pathway and joint working procedure.

Dual Diagnosis Assessment and Treatment Pathway – (*Appendix 1*)

1. Referral of individual into either Adult Mental Health or Substance Misuse Services.

2. Initial assessment of an individual to gain background information, identification of current needs and eligibility for receipt of services.

3. Identification of Dual Diagnosis through initial assessment. Where Dual Diagnosis is identified a referral will be made to Substance Misuse Services by AMH or AMH via Substance Misuse Services.

4. Following identification of Dual Diagnosis by either Substance Misuse or Adult Mental Health Service, AMH will allocate a Care Co-ordinator and Substance Misuse a Co-worker who will agree to meet with the client to develop a joint Care Plan. In this arrangement the allocated Care Co-ordinator maintains lead responsibility for the case.

5. AMH and Substance Misuse proceed with treatment intervention and monitoring progress against the Care Plan objectives.

6. Treatment interventions in either service may include Community Statutory, Non Statutory, Structured Day Care, Counselling and others and will be subject to a 3 monthly multi-agency Care Plan Review.

7. When either AMH or Substance Misuse complete treatment interventions with the client they will discharge to the other service. If further needs are identified the client may return to points 2, 3, 4, 5 or 6 in the Pathway as appropriate.

8. In the event that all Care Plan objectives are met the client may be discharged to Primary Care or Non Statutory Support services.

10. Special Consideration Groups.

Safeguarding Vulnerable Children and Adults

The Children Act, sets out the responsibilities of local authorities and other services for protecting children and promoting their welfare. The key principle of the Act is that the well-being of the child is paramount. The Act places a duty on agencies engaging with people who misuse substances who have dependent children and on mental

health services to access the needs of children, their health and well-being as they may be at risk. The Act states that parents should normally be responsible for their children. This implies that health and social care agencies should not separate the child from the parents unless it is clearly in the interests of the child to do so.

Within the risk assessment full account should be taken of the particular challenges posed by parents with dual diagnosis problems, and the need for supervision, staff training, assessment, care management, and inter- agency liaison.

11. Information Sharing

The principle of confidentiality should not be used to prevent the sharing of information where risk to the client or others including dependant children, has been identified. The client and where appropriate the carers should be informed of information shared.

Although, cognisance must be taken of the common law duty of confidence, Human Rights Act 1998, Data Protection Act 1998, in general, the law will not prevent the sharing of information with other practitioners if:-

- Those likely to be affected consent
- The public interest in safeguarding the child's welfare overrides the need to keep the information confidential.
- Staff and members of the public are kept safe (MAPPA)
- Disclosure is required under a court order or other legal obligation

The Criminal Justice Act 2003 imposes a duty to cooperate on NHS Trusts and other agencies with police/probation/prisons in the management of offenders who may pose an ongoing risk to the community. This does not override the common law duty upon health professionals to protect patient confidentiality.

"Under common law, staff are permitted to disclose personal information in order to prevent and support detection, investigation and punishment of serious crime and/or to prevent abuse or serious harm to others where they judge, on a case by case basis, that the public good that would be achieved by the disclosure outweighs both the obligation of confidentiality to the individual patient concerned and the broader public interest in the provision of a confidential service."

(NHS 2003 Confidentiality Code of Practice DH)

The principles are that information sharing must:-

- Have lawful authority
- Be necessary
- Be proportionate; and done in ways which
- Ensure the safety and security of the information shared; and
- Be accountable.

Services and agencies should work together to overcome misunderstandings and/or agency differences in order to protect the best interests and promote the best possible range of care for dual diagnosis clients.

It is vitally important that joint working and good communications between all involved should be maintained throughout to effectively address the needs of clients. This should be ensured by the CPA process/Models of Care system and include the client and carers. Robust record keeping will be required.

Care co-ordinators and local workers will be expected to attend meetings/reviews and present reports when required together with the general sharing of plan, problems and changing needs.

A higher level or regular contact should be established and maintained with a clear emphasis that any change in circumstances be shared on a need to know basis.

12. Training

Training locally has been identified by a Training Needs Analysis and the Dual Diagnosis audit.

(*Appendix ii,iii*)

The recommendations were;

A number of areas for Training were identified in order to comply with the Dual Diagnosis strategy.

1. General understanding of the definition of Dual Diagnosis
2. Familiarity of the Dual Diagnosis Strategy
3. Staff's working knowledge of Service Eligibility Criteria
4. Record and Record Keeping
5. Specific Training for the Treatment of Dual Diagnosis Patients

There were also some areas where interagency planning would be beneficial.

1. Development of joint working initiatives such as care Planning and review
2. Development of Service User involvement strategy
3. Information Sharing Protocol

A Training programme has been developed to meet the needs of staff locally and will be provided monthly to all appropriate staff.

Programme aims
To raise awareness of dual diagnosis and the underpinning of the dual diagnosis strategy.

Programme objectives
By the end of the training session participants will be able to:

- Define the term dual diagnosis
- Share their own experiences in working with this client group
- Have increased awareness of ways of working with dual diagnosis patients.
- Gain an understanding of local mental health services and care pathways for dual diagnosis clients (CPA)

- Gain an understanding of local substance misuse services and care pathways for dual diagnosis clients (CPA)
- Identify barriers and aids to engagement (DICES)

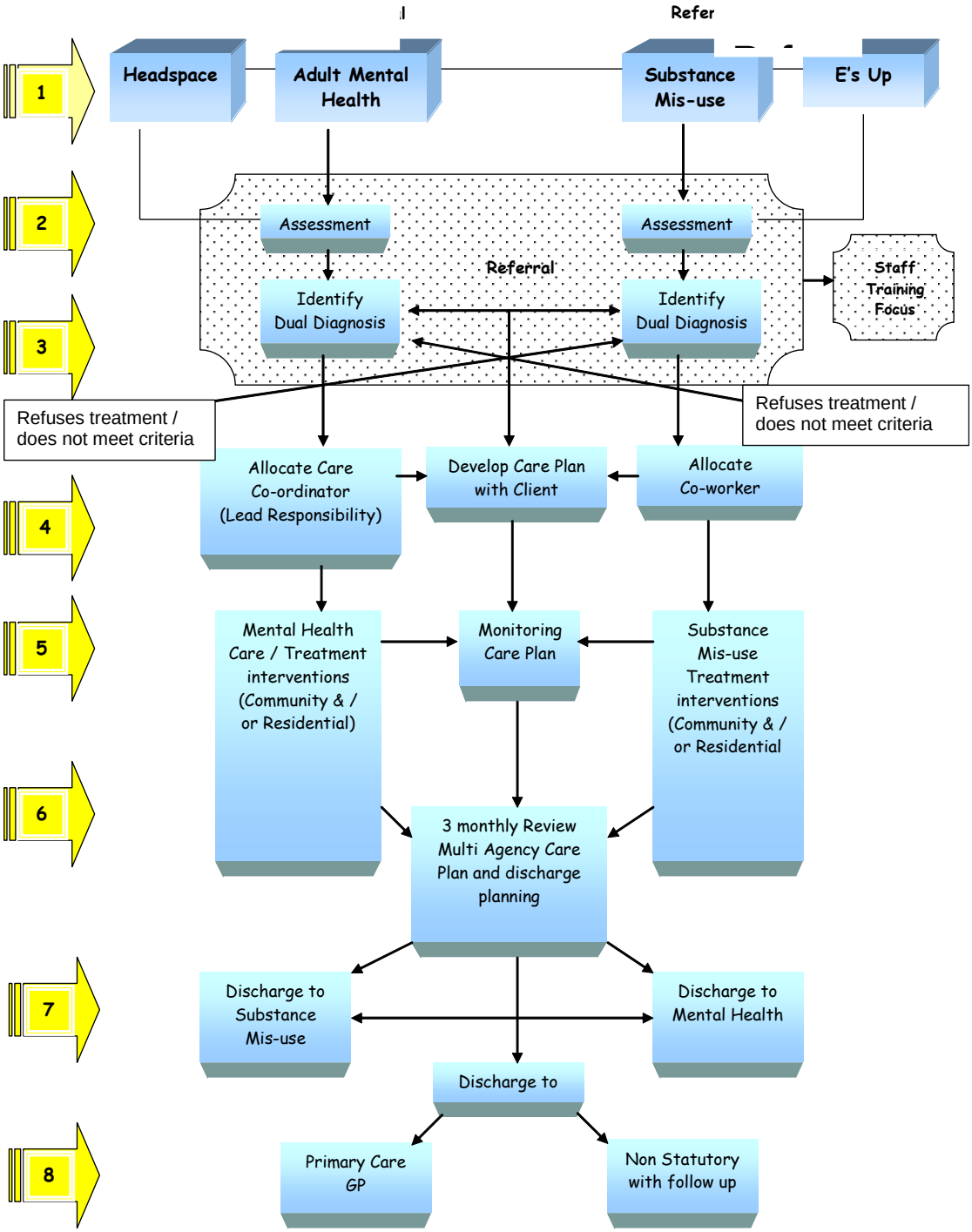
Information Sharing Workshops will be organised annually to ensure teams are kept up to date with referral criteria and service developments.

13. Evaluation and Audit Programme

- Dual Diagnosis Standard and Measurement – Monitored Annually
- Training Needs Analysis – Monitored Annually
- Training Programme – Ongoing evaluation and end of year review
- Dual Diagnosis Strategy Action Plan (Appendix iv) – Ongoing monitoring by Dual Diagnosis Steering group.

APPENDICES

i – Dual Diagnosis Treatment Care Pathway



ii. – Training Needs Analysis

Dual Diagnosis Training Needs Analysis – Mental Health Practitioners				
Staff Name;		**Team/Unit;**		**Job Title;**
Substance Misuse Training Received	**Date/Year Received**	**Specific Dual Diagnosis Training Received**	**Date/Year Received**	**Identified Dual Diagnosis/Substance Misuse Training Required**

iii. – Dual Diagnosis Standard and Measurement

Standard

Category: Clinical

Topic: Dual Diagnosis Care Pathway

Standard Statement: To ensure staff are providing Treatment interventions as described in the Adult Mental Health and Substance Misuse Dual Diagnosis Protocol.

CRITERIA

1. **All staff have received appropriate training in Dual Diagnosis, Mental Health and Substance Misuse.**

2. **Dual Diagnosis is identified as part of the initial Mental Health or Substance Misuse assessment**

3. **Patients are appropriately referred to either the Mental Health or Substance Misuse services**

4. **Referral Criteria is met**

5. **All Dual Diagnosis Patients are given information relating to Data Protection, Confidentiality and Information sharing.**

6. **All Dual Diagnosis Patients have a joint care plan involving Mental Health, Substance misuse and the Service User/Carer**

7. **All Dual Diagnosis Patients have a completed risk assessment**

8. **Each Care plan has a three monthly multi-agency review**

9. **A discharge plan is in place for all Patients leaving the service**

DUAL DIAGNOSIS STANDARD
OUTCOME MEASUREMENT

To be monitored at 3 monthly intervals

This form is designed to be used by the team member responsible for monitoring standards.
Any problems detected must be reported to the person in charge / Co-ordinator responsible for the area. This will enable corrective action to be taken.

By checking six sets of participating service users records and discussing with staff:

1. Can Staff produce evidence of appropriate Dual Diagnosis, Mental Health, Substance Misuse training? ☐ **Yes** ☐ **No**

2. Is there evidence that a full assessment of need has been completed and Dual Diagnosis needs identified ☐ **Yes** ☐ **No**

3. Is there evidence that the Patient meets the criteria for referral to the Mental Health or Substance Misuse Service ☐ **Yes** ☐ **No**

4.Is it recorded that Patients have received information relating to Data protection, Confidentiality and Information sharing? ☐ **Yes** ☐ **No**

5. Is there evidence of an up to date joint care plan signed by the patient ☐ **Yes** ☐ **No**

5. Is there evidence of an up to date risk assessment? ☐ **Yes** ☐ **No**

6. Is there evidence that the care plan has been reviewed by all agencies involved in the patients care? ☐ **Yes** ☐ **No**

7. Is there evidence of a completed discharge plan prior to the patient leaving the service ☐ **Yes** ☐ **No**

iv – Dual Diagnosis Strategic Action Plan

No.	Objective	Actions	Date	Achievements
1	Develop Dual Diagnosis Steering group	Steering group in place with appropriate membership including service user/carer involvement to oversee the development and implementation of the Protocol	March 07 11.07.07	Steering group developed, membership agreed with the addition of service user/carer involvement form mental health. Purpose, frequency, duration and location agreed Terms of reference discussed and agreed.
2	Clear guidance for all practitioners	Develop and agree joint working protocol across all agencies to include: • The definition of dual diagnosis • What each agency offers for the client group • Agreed integrated care pathway including referral arrangements, assessment, service provision including care planning / CPA arrangements, arrangements for discharge from hospital and prison, and shared-care • Dispute procedure where there is disagreement on which service should take responsibility for assessment or key working. • Philosophy of service provision which incorporates harm reduction and outreach models of intervention • Information sharing between agencies • Develop final Joint working protocol	 June 06 Oct 07 11.07.07 11.07.07 Oct 07 Aug 07 Dec 07	Definition agreed as part of Dual Diagnosis Strategy Agreed to plan and implement a workshop for staff and service users to give small presentations of service provision and eligibility criteria Integrated Care Pathway developed and agreed at steering group. Procedure for dispute of Care Pathway Developed and agreed at steering group. Develop a joint Philosophy Identify joint information sharing protocol

No.	Objective	No.	Actions	Date	Achievements
3	Appropriately trained and supported workforce	3.1	Develop an ongoing comprehensive training programme taking into consideration teams identified as carrying significant levels of dual diagnosis clients: • PORT • Crisis Resolution and Home Treatment Team • Mendos • Gateway workers – Homeless & Prison In reach	15.02.07	Areas of initial training needs agreed in relation to care Pathway. Clarify specific training needs
		3.2	Develop a network of experts & supervision arrangements		
4	Ensure the needs of Special Groups are met	4.1	Provide for the needs of young dual diagnosis service users within the developing Early Intervention team	Feb 07 11.07.07	Joint working protocol developed between 'Headspace' and 'E's Up' and agreed at Steering group
		4.2	Take account of the needs of women service users in the developing of the women's strategy		Refer to the AMH strategy for women when identifying training needs and developing Dual Diagnosis protocol
		4.3	Develop joint working arrangements with criminal justice substance misuse services i.e. Drug Intervention Programme	March 07	Joint working protocol developed and implemented between Adult Substance Misuse service and DIP
5	Support primary care	5.1	Explore possibilities for service development and support for GPs within a primary care setting via shared care and primary care gateway		

No.	Objective	No.	Actions	Date	Achievements
6	Robust data collection to evidence need and trends to inform future service development	6.1	Agree data collection method and parameters		Presentation set up to explore feasibility of introducing new integrated IT system RIO. Tendering process for substance misuse IT system almost completed
7	Audit outcomes and compliance with Dual Diagnosis protocol	7.1	Develop a base Line audit	July 07	Standard and measurement developed to monitor compliance with Treatment Pathway; awaiting feedback from steering group
		8.2	Develop and implement a full audit	April 08	